UPDATE

Disease
Non-battle
Injury
in the Korean
Theater

No. 3; Vol. 1
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*A Publication of the 18th MEDCOM Preventive Services Directorate*

*"Preserving the Fighting Strength"*

# INTRODUCTION

This month's focus is on detecting and treating latent tuberculosis infections. This is partially in recognition of the World Health Organization's declaration of March 22nd as "World TB Day," a day to reflect on the strides made in combatting tuberculosis over the last year. A great deal has changed in the areas of tuberculosis prevention and treatment, and all providers should utilize the most up-to-date information. In addition, 5-6 hours of ***free*** CME/CE credit can be earned by completing the CDC's *Core Curriculum on Tuberculosis,* which is available at www.cdc.gov/nchstp/tb/pubs/corecurr.

## TB: Fighting an Ancient Enemy

Tuberculosis is a disease spread through respiratory droplets containing the bacteria *M. tuberculosis*. It has been present since antiquity. Many earlier works refer to it as "consumption," thus creating many tragic heroes and heroines dying of this romanticized illness, such as Beth in *Little Women*. In truth, consumption, or tuberculosis, is far from romantic. This disease was responsible for 1 out of every 7 deaths in the United States and Europe during the late 19th century. As recently as 1953 it was the leading cause of death in Korea. And certainly war veterans brought it back home with them.

The Assistant Chief of the TB Service at the Fitzsimons Army Hospital recalls "We had an 80-bed ward full of young men returning from Korea with what was then called "idiopathic pleural effusion." Because of the occasional need to explore one of these, we learned that such effusions were due to soiling of the pleura by a small subpleural lesion of primary TB in the lower half of one lung."

Today, tuberculosis is the second-leading infectious cause of death around the globe, killing approximately 2 million people every year. The Centers for Disease Control and Prevention (CDC) estimate that someone is newly infected with TB every second. Frightening? Yes. But aggressive public health measures have resulted in declining disease incidence in both the United States and the Republic of Korea.

## US Experience

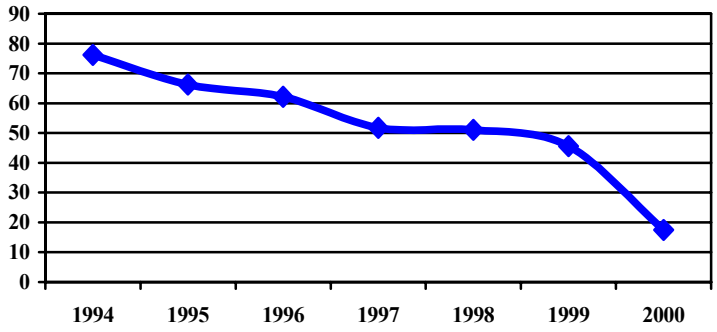
Since the most recent peak in TB incidence in 1992, TB has continued on a downward trend. Some authors feel that this indicates the US is fully recovered from the resurgence of TB that occurred in the late 1980s and is back on track toward TB elimination. The most recent summarized data is from 2000, and shows TB incidence rates to be down to 5.8 cases/100,000 population, for a total of 16,377 cases of active TB disease. 46% of these cases occurred in foreign-born persons.

## Korean Experience

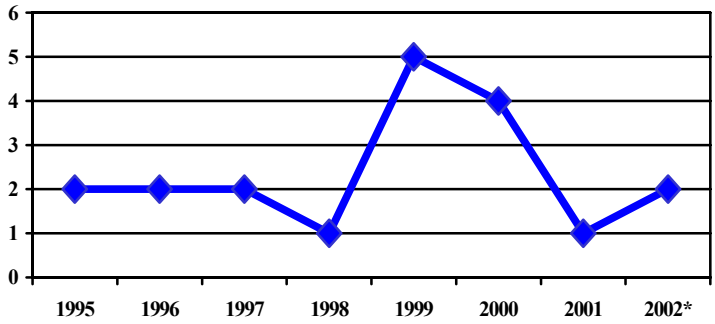
This figure shows that Korea is experiencing a similar decline in their rate of TB disease per 100,000 population. While it is declining, their most recent data demonstrate their rate is still three times that of the United States. The BCG vaccine is used in Korea.

Some reporters suggest one reason for the decline in tuberculosis rates in 2000 lies with the physician strike and work slow-down that occurred over the better part that summer. Diagnosed cases may have gone unreported, thus influencing the graph's curve.

Economic hardships imposed by the IMF difficulties, influxes of foreign workers from countries with high rates of TB disease and a growing population of elderly all contribute to the difficulties Korea faces in her fight for TB elimination.




## USFK Experience




The chart to the right shows the number of reported active TB cases among 18th MEDCOM beneficiaries since 1995. Two active cases have been reported to date in 2002.

## Latent vs Active Disease

The terms 'latent' and 'active' tuberculosis disease often cause confusion, and can be difficult to explain to patients.
Latent tuberculosis infection refers to infection that the immune system is able to control. These persons cannot infect others, and sputum exams and cultures in these people will be negative. Chest x-rays will be normal. Latent infection is detected with the TB skin test. The Mantoux purified protein derivative (PPD) test is used in the US. It consists of the intradermal injection of .5ml of PPD. This skin test is considered "positive" based on the size and nature of the reaction that develops at the site of the test 48 to 72 hours after the inoculation. A person who has received the BCG vaccine can still undergo PPD testing.

Active tuberculosis refers to tuberculosis infection to which the body is unable to mount resistance. In the US, reactivation of latent infection is the most common source of active disease. These patients are usually highly infective to others. Typical symptoms include fever, weight loss, night sweats, and a persistent productive cough. However, it is important to remember that not all patients will present with a classic picture.

Up to 82% of people whose skin test converts will develop active TB disease within two years. Because it is impossible to predict who will or won't develop the disease, anti-tubercular medications are administered to prevent the person from developing active disease at a later point in life. Once a person's skin test is positive then future PPDs are generally not warranted since the reaction will likely remain positive.

### Notable changes from previous recommendations

**TB testing**
- A conversion is defined as an increase of >/=10mm of induration within a 2-yr period, regardless of age
- Targeted testing of high-risk groups is preferred to mass screening

**Treatment of LTI**
- INH for 9 months is preferred over 6 month regimens in HIV- persons
- INH for 9months is adequate for HIV+ persons and for those with fibrotic lesions on CXR suggestive of previous TB

**Clinical and Laboratory Monitoring**
- Routine baseline and follow-up labs can be eliminated in most persons with LTBI, EXCEPT those with HIV, pregnant and immediate post-partum women, persons with chronic liver disease or those who use alcohol regularly.

## Sputum Specimens

Any patient from an outlying clinic or aid station should be transported to the Seoul Army Community Hospital for sputum collection and testing. While this may be less than ideal for busy persons at the farthest reaches of the peninsula, this is necessary in order to ensure an adequate, appropriate specimen is collected and assayed in a timely manner. Delays in testing can reduce the ability to detect a positive specimen. If clear arrangements for communicating results are in place, local hospitals under Tricare approval may be utilized in some instances.

## Treatment Options

PPD-positive individuals with chest x-ray findings or symptoms suggestive of TB can be started on a four-drug regimen while awaiting culture and sensitivity results. 10 days of treatment have been shown to render patients incapable of transmitting the disease to others. Respiratory precautions should be observed during the initial 10-day treatment, however. The four-drug regimen must be continued until culture results are available.

Otherwise, healthy persons whose skin test converts (>10mm induration) while they are in Korea should be started on a nine-month course of INH. B6 vitamin is given daily to prevent side effects of INH. If compliance appears to be a problem for the person, a two-month course of rifampin and INH with B6 is an option.

Liver function monitoring has become a controversial issue of late. While in the past frequent monitoring was often provided at frequent intervals, recent studies show that healthy younger people generally do not need monitoring. Older people, persons who consume alcohol or Tylenol and people who have sustained liver insults, such as hepatitis, will benefit from monitoring. Generally, initial increases of 3 times baseline may be seen, but this should wane, and INH therapy can be continued. Persistent increases or increases beyond this degree will require assessment and either an alternate dose scheduling or termination of INH. The Preventive Medicine Consultant should be contacted when such issues arise (736-3025).

## Preventing Tuberculosis Disease

Active Duty personnel receive the PPD skin test as part of their routine out-processing requirements from the Republic of Korea. The Department of Defense Schools has an annual PPD testing requirement and several occupations also have annual requirements. Family members should also be tested at the time of departure or 90 days after return to the United States. While every person with a positive (>10mm induration—not erythema alone) skin test MUST be referred to the local Community Health Nurse (CHN) for evaluation and treatment, the service and/or family member will still be able to PCS on schedule. They will, however, need to arrange follow-up with the local CHN upon arrival at the next duty location to ensure treatment continuity. If there are any questions do not hesitate to contact your local public health authority or contact the Preventive Services Directorate at 736-3025.

**Resources:**

## *Community Health Nurses*

| | | |
|---|---|---|
| AREA I: | CPT J. Walker | 730-6796 |
| AREA II: | CPT R. Cichy | 725-5128 |
| AREA III: | CPT K. Hill | 753-8355 |
| AREA IV: | CPT M. Cristal | 764-4819 |

Centers for Disease Control and Prevention, 'Targeted Tuberculin Testing' and 'Core Curriculum on Tuberculosis'

International Union Against TB and Lung Disease: http://www.iuatld.org

Korean Ministry of Health

Korean Herald

# ANTIBIOGRAM 2001

**Outpatient** origin: 1 Feb 01 – 31 Jan 02

**( ) # of isolates tested during reporting period; Number of Isolates Tested may include multiple isolates**

| % Susceptible | AMP | CEF | CTX | CIP | GEN | PEN | OX | CLIN | ERY | TCN | NF | TMP/ SMX | VAN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Enterobacter aerogenes **(12)** | 8 | 33 | 100 | 100 | 100 | | | | | 100 | 67 | 100 | |
| Enterobacter cloacae **(3)** | 0 | 0 | 100 | 100 | 100 | | | | | 100 | 100 | 100 | |
| Escherichia coli **(245)** | 51 | 98 | 100 | 91 | 93 | | | | | 70 | 98 | 73 | |
| Klebsiella pneumoniae **(22)** | 5 | 100 | 95 | 100 | 90 | | | | | 95 | 95 | 95 | |
| Neisseria gonorrhoe **(31)** | | | 100 | 87 | | 55 | | | | | | | |
| Pseudomonas aeruginosa **(10)** | 0 | 0 | 34 | 100 | 90 | | | | | 0 | 0 | 0 | |
| Staphylococcus aureus **(57)** | 40 | 87 | 100 | 100 | 96 | 9 | 88 | 98 | 94 | 89 | 97 | 96 | 100 |
| Enterococcus faecalis **(14)** | 100 | | | 100 | 82 | 93 | | | | 16 | 100 | | 93 |
| Streptococcus pneumoniae **(2)** | | | | | | *S *R | | | *S *R | *S *R | | *S *R | *S *S |

**AMP** = ampicillin **CEF** = cefazolin **CTX** = ceftriaxone **CIP** = ciprofloxacin **GEN** = gentamicin **PEN** = penicillin
**OX** = oxacillin **CLIN** = clindamycin **ERY** = erythromycin **TCN** = tetracycline **NF** = nitrofurantoin
**TMP/SMX** = trimethoprim/sulfamethoxazole **VAN** = vancomycin
*S = Susceptible *R = Resistant

**NOTES**:

1. ***Staphylococcus aureus***: Eight patients were infected with Methicillin Resistant *Staphylococcus aureus* (MRSA) during the study period. Isolates tested more than once were included in this data.
2. ***Enterococcus faecalis***: One patient was infected with Vancomycin-Resistant *Enterococcus* (VRE) during the study period.
3. ***Streptococcus pneumoniae***: One patient was infected with *Streptococcus pneumoniae* during the study period.
4. * In order to avoid misrepresenting the antibiotic susceptibility for small number of isolates, *Streptococcus pneumoniae*, percentage of susceptibility has not been calculated. Those isolates are reported as either susceptible or resistant to the antibiotics.

**121 GH Inpatient** origin: 1 Feb 01- 31 Jan 02
**( ) # of isolates tested during reporting period; Number of Isolates Tested may include multiple isolates**

| % Susceptible | AMP | CEF | CXM | CTX | TAZ | CIP | GEN | IMI | PEN | OX | TMP/ SMX | VAN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Escherichia coli **(18)** | 16 | 77 | 100 | 100 | 100 | 67 | 67 | | | | | |
| Klebsiella pneumoniae **(1)** | *R | *S | | *S | *S | *S | *S | | | | *S | |
| Pseudomonas aeruginosa **(10)** | 0 | 0 | | 25 | 100 | 80 | 100 | 100 | | | 0 | |
| Staphylococcus aureus **(18)** | 20 | 63 | | | | 72 | 88 | | 11 | 61 | 100 | 100 |
| | *S | | | | | *S | *S | | *S | | | *S |
| Enterococcus faecalis **(2)** | *S | | | | | *S | *S | | *S | | | *S |
| Streptococcus pneumoniae **(1)** | | | | *S | | *S | | | *R | | *R | *S |

**AMP** = ampicillin **CEF** = cefazolin **CXM** = cefuroxime **CTX** = ceftriaxone **TAZ** = ceftazidime **CIP** = ciprofloxacin
**GEN** = gentamicin **IMI** = imipenem/cilastatin **PEN** = penicillin G **OX** = oxacillin
**TMP/SMX** = trimethoprim/sulfamethoxazole **VAN** = vancomycin
*S = Susceptible *R = Resistant

## NOTES:

1. ***Staphylococcus aureus***: Four patients were infected with Methicillin Resistant *Staphylococcus aureus* (MRSA) during the study period. Isolates tested more than once are included in this data.
2. ***Enterococcus faecalis***: There were no Vancomycin-Resistant *Enterococcus* (VRE) isolates during the study period.
3. ***Streptococcus pneumoniae***: One patient was infected with Penicillin Resistant *Pneumoniae* (PRP) during the study period.
4. * In order to avoid misrepresenting the antibiotic susceptibility for small number of isolates, including *Klebsiella pneumoniae, Enterococcus faecalis* and *Streptococcus pneumoniae*, percentage of susceptibility has not been calculated. Those isolates are reported as either susceptible or resistant to the antibiotics.

**---contributed by Mrs. Jana Lee, R.Ph, Department of Pharmacy and Ms. Chin Su Sin, Microbiologist, Department of Pathology**

# COST OF STOCKED INJECTABLE ANTIBIOTICS

| Drug | Usual Adult Dose | Usual Regimen | Daily Inpatient Cost $ (Does not include labor cost) |
|---|---|---|---|
| **AMINOGLYCOSIDES** | | | |
| Amikacin | 15mg/kg | q24h | 6.81 ( for wt=70kg) |
| Gentamicin | 7mg/kg | q24h | 2.76 ( for wt=70kg) |
| Tobramycin | 7mg/kg | q24h | 15.97(for wt=70kg) |
| **1st Generation CEPHALOSPORINS** | | | |
| Cefazolin | 1gm – 2gm | q8h | 6.40 – 9.55 |
| **2nd Generation CEPHALOSPORINS** | | | |
| Cefoxitin | 1gm – 2gm | q6h | 17.14 – 30.96 |
| **3rd Generation CEPHALOSPORINS** | | | |
| Cefotaxime | 1gm – 2gm | q8h | 19.52 – 36.78 |
| Ceftazidime | 1gm – 2gm | q8h | 19.50 - 36.50 |
| Ceftriaxone | 1gm – 2gm | q24h | 22.34 – 43.22 |
| **MACROLIDE** | | | |
| Azithromycin | 500mg | q24h | 13.86 |
| Erythromycin | 500mg – 1gm | q6h | 7.17 – 9.94 |
| **PENICILLINS** | | | |
| Ampicillin | 1gm – 2gm | q6h | 5.59 – 6.94 |
| Ampicillin/Sulbactam | 1.5gm – 3gm | q6h | 22.88 – 41.35 |
| Nafcillin | 1gm | q4h | 10.12 |
| Penicillin G Potassium | 2MU | q4h | 12.24 |
| Piperacillin | 2gm – 4gm | q4-6h | 32.45 – 38.91 |
| **QUINOLONES** | | | |
| Ciprofloxacin | 200mg-400mg | q12h | 19.53 – 37.01 |
| Levofloxacin | 250mg-500mg | q24h | 8.87 – 20.88 |
| **MISCELLANEOUS** | | | |
| Clindamycin | 600mg – 900mg | q8h | 10.02 – 11.12 |
| Doxycycline | 100mg | q12h | 15.92 |
| Imipenem-Cilastatin | 500mg | q6h | 69.54 |
| Metronidazole | 500mg | q6h | 25.69 |
| Trimethoprim/Sulfamethoxazole | 160/800-320/1600 | q6h | 5.46-8.36 |
| Vancomycin | 500mg – 1gm | q6h - q12h | 25.00 |

# COST OF STOCKED ORAL ANTIBIOTICS

| Drug | Usual Adult Dose | Usual Regimen (10 days duration unless noted otherwise) | Cost of usual regimen $ (Does not include labor cost) |
|---|---|---|---|
| **1ST Gen. CEPHALOSPORIN** | | | |
| Cephalexin | 250mg – 500mg | q6h | 2.66 – 5.33 |
| **2nd Gen. CEPHALOSPORINS** | | | |
| Cefuroxime | 250mg – 500mg | q12h | 45.37 –90.75 |
| **3rd Gen. CEPHALOSPORINS** | | | |
| Cefpodoxime (oral suspension available) | 200mg | q12h | 29.62 |
| **MACROLIDES** | | | |
| Azithromycin | 500mg Day1, then 250mg | q24h for 4days | 24.83 (Z-pak) |
| Clarithromycin(restricted for h.pylori tx only) | 500mg | q12h for 14 days | 46.64 |
| Erythromycin | 250mg - 500mg | q6h | 1.65 – 3.30 |
| **PENICILLINS** | | | |
| Amoxicillin | 250mg – 500mg | q8h | 1.19 – 2.38 |
| Amoxicillin/Clavulanate | 200mg – 400mg | q12h | 22.46 –43.82 |
| Amoxicillin/Clavulanate | 500mg | q12h | 45.54 |

| | | | |
|---|---|---|---|
| Amoxicillin/Clavulanate | 875mg | q12h | 64.06 |
| Dicloxacillin | 125mg – 250mg | q6h | 2.00 |
| Penicillin V Potassium | 250mg – 500mg | q6h | 0.90 – 1.80 |
| **QUINOLONES** | | | |
| Ciprofloxacin | 250mg | q12h | 29.88 |
| Ciprofloxacin | 500mg | q12h | 33.66 |
| Levofloxacin | 250mg – 500mg | q24h | 19.70 |
| **TETRACYCLINES** | | | |
| Doxycycline | 100mg | q12h | 1.02 |
| Minocycline | 100mg | q12h | 4.43 |
| Tetracycline | 250mg – 500mg | q6h | 1.86 – 3.72 |
| **MISCELLANEOUS** | | | |
| Clindamycin | 150mg – 300mg | q6h | 9.86 – 19.72 |
| Metronidazole | 250mg - 500mg | q6-8h | 0.86 –1.28 |
| Nitrofurantoin | 50mg – 100mg | q6h | 13.85 – 27.70 |
| Nitrofurantoin SR | 100mg | q12h | 18.18 |
| TMP/Sulfamethoxazole | 160/800mg | q12h | 1.40 |

## COST OF STOCKED PEDIATRIC ANTIBIOTIC SUSPENSIONS

| Drug | Usual Pediatric Dose | Usual Regimen (10 days duration unless noted otherwise) | Cost per Bottle for usual regimen ($) (Does not include labor cost) |
|---|---|---|---|
| **CEPHALOSPORINS** | | | |
| Cephalexin | 125mg | q6h | 1.53 |
| Cephalexin | 250mg | q6h | 2.10 |
| Cefpodoxime | 100mg | q12h | 14.81 |
| **MACROLIDES** | | | |
| Azithromycin<br>(Note: Savings are achieved by using 200mg/5ml and giving 2.5ml to provide a 100mg dose) | 100mg(100mg/5ml)<br><br>200mg(200mg/5ml) | q24h for 5 days | 17.34 (15ml/BTL)<br><br>18.59 (30ml/BTL) |
| Erythromycin (EES) | 200mg | q6h | 5.53 |
| Erythromycin/Sulfisoxazole (Pediazole) | 200/600 (5ml) | q6h | 7.48 |
| **PENICILLINS** | | | |
| Amoxicillin | 125mg | q8h | 0.90 |
| Amoxicillin | 250mg | q8h | 1.31 |
| Amoxicillin/Clavulanate | 200mg | q12h | 19.00 |
| Amoxicillin/Clavulante | 400mg | q12h | 42.93 |
| Dicloxacillin | 62.5mg | q6h | 7.71 |
| Penicillin V Potassium | 250mg | q6h | 3.09 |
| **MISCELLANEOUS** | | | |
| Clindamycin | 75mg | q6h | 8.09 |
| Nitrofurantoin | 50mg | q6h | 22.27 |
| Sulfisoxazole | 500mg | q6h | 10.87 |
| Trimethoprim/Sulfamethoxazole | 40/200 (5ml) – 80/400 (10ml) | q12h | 0.24 – 0.48 |

# DISEASE TRENDS

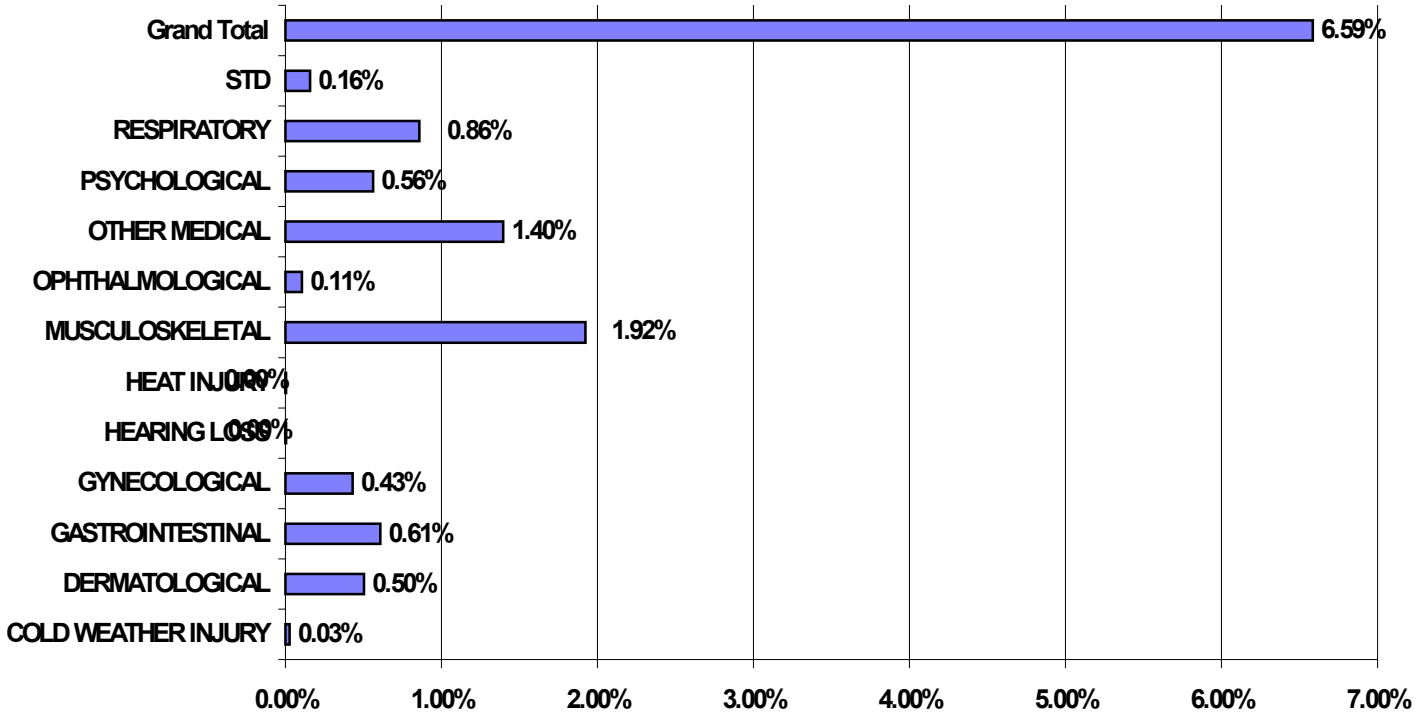
**18th MEDCOM Reportable Events Program**

## Selected Reportable Events Incidence Summary
## FEB 2002

| Reportable Condition | Area I | Area II | Area III | Area IV | Totals |
|---|---|---|---|---|---|
| Trichomonas | NR | NR | NR | NR | NR |
| Chlamydia | 2 | 4 | 7 | 3 | 16 |
| Herpes simplex | NR | NR | NR | NR | NR |
| Gonorrhea | 0 | 2 | 3 | 1 | 5 |
| STD Totals | 2 | 6 | 10 | 4 | 21 |
| Tuberculosis (active disease) | 0 | 1 | 1 | 0 | 2 |
| Tuberculosis (recent converter) | NR | NR | NR | NR | NR |
| Animal Bites | 0 | 3 | 1 | 0 | 4 |
| Cold Weather Injuries | NR | NR | NR | NR | NR |
| Suicide Gesture/Attempt | 2 | 3 | 1 | 2 | 7 |
| Deaths from all causes | 0 | 0 | 0 | 0 | 0 |

NR=None Reported

## Distribution of Disease Non-Battle Injury Medical Visits for Active Duty US Army Members Seen in 18th MEDCOM Clinics February 2002




**Editor's Note:** Data for above chart was generated through a manual review of KG-ADS diagnoses given each active duty US Army patient seen in 18th MEDCOM primary care, urgent care, and women's health clinics. Percentages are calculated based on total 8th US Army strength. Only one visit for the same disease or injury category was counted. Only KG-ADS data completed within a week or less of the patient visit was accessible. While DNBI tracking traditionally differentiates recreational injuries from training injuries and MVA injuries, the lack of information pertaining to cause of injury in KG-ADS made this impossible to determine.

# Reported Events Summary, USFK: February 2002

| Conditions | | Feb 2002 | Cum 2002 | Cum 2001 |
|---|---|---|---|---|
| **STD** | Chlamydia | 16 | 48 | 45 |
| | Gonorrhea | 6 | 15 | 26 |
| | Herpes Type II | 0 | 1 | 2 |
| | HIV/AIDS | 0 | 0 | |
| | Trichomonas | 0 | 3 | |
| | Syphilis | 0 | 0 | 1 |
| **Infectious Diseases** | Campylobacter | 0 | 0 | |
| | Cholera | 0 | 0 | |
| | E.Coli 0157:H7 | 0 | 0 | |
| | Encephalitis | 0 | 0 | |
| | Giardiasis | 0 | 0 | |
| | Hepatitis A | 0 | 0 | |
| | Hepatitis B | 0 | 0 | |
| | Hepatitis C | 0 | 0 | |
| | Influenza | 0 | 0 | |
| | Measles | 0 | 0 | |
| | Meningitis | 0 | 0 | 1 |
| | Pneumococcal Pneumonia | 0 | 0 | |
| | TB, Active | 2 | 2 | 1 |
| | PPD Conversion | 0 | 5 | 19 |
| | Salmonellosis | 0 | 2 | 3 |
| | Shigellosis | 0 | 0 | |
| | Typhoid Fever | 0 | 0 | |
| | Varicella, adult | 0 | 1 | 2 |
| **Vector-borne Diseases** | Dengue Fever | 0 | 0 | |
| | Ehrlichiosis | 0 | 0 | |
| | HFRS | 0 | 0 | |
| | Japanese Encephalitis | 0 | 0 | |
| | Leptospirosis | 0 | 0 | |
| | Malaria | 0 | 1* | 12^ |
| | Rabies | 0 | 0 | |
| | Scrub Typhus | 0 | 0 | |
| **Injuries** | Animal Bites | 4 | 6 | 17 |
| | Cold Injury | 0 | 2 | |
| | Heat Injury | 0 | 0 | 5 |
| | CO Poisoning | 0 | 0 | |
| | Lead poisoning | 0 | 0 | |
| | Hearing Loss | 0 | 0 | |
| **Immunization** | VAERS | 0 | 0 | |
| | Influenza | 0 | 0 | |

***Notes***:
**Disease contracted outside ROK*
**^**Indicates cases diagnosed while in ROK; additional 12 cases were diagnosed after return to US*
***Please refer to the reverse of the 18th MEDCOM IHO Reportable Events Worksheet for a complete listing of reportable events. A copy of this form is included at the end of this document.***

EAMC FORM 600, NOV 2001

# 18th MEDCOM IHO REPORTABLE EVENTS WORKSHEET

## PATIENT DATA

**Last Name** | **First Name**

**FMP** | **Social Security Number** ___ — ___ — ___ | **Date of Birth** ___ (Day) ___ (Month) ___ (Year)

**Residence -** City or Location (*e.g.* Yongsan)

**Gender:** ○ MALE ○ FEMALE

**APO**

**Race:** ○ WHITE ○ ASIAN ○ BLACK ○ AM. INDIAN ○ HISPANIC ○ OTHER

**Category*** | **Grade** | **Unit** | **UIC**

**Unit Location -** (*e.g.* CP Casey) | **Duty Phone** ___ — ___

## REPORTING SOURCE

**Submitting Health Care Provider:** _____

**Comments/Additional Information:**

**CHN/Clinic:** _____

**Phone #:** _____

1. Refer to the list on the back of this form to determine if a patient's disease/condition is reportable.
2. Complete one worksheet per disease (vs. per patient in cases of multiple diagnoses) while the patient is still present.
3. Indicate if the disease/condition is suspected or confirmed and what testing has been done (i.e., culture, serology, etc.). Community Health Nursing personnel will help track the results.
4. Diseases/conditions followed by an asterisk (*) also require immediate telephone reporting to your Area Community Health Nurse to initiate disease control measures (Area I 730-6796, Area II 725-5128, Area III 753-8355, Area IV 764-4819). After duty hours, contact the Community Health Nursing Consultant through the 121st General Hospital Emergency Department.
5. Forward completed worksheets to Commander, 18th MEDCOM, Attn: EAMC-CHN, APO AP, 96205-0020 or FAX to 736-3028.

### HEAT OR COLD INJURIES ONLY

**Ambient temperature** ___ . ___ ºC / ºF

**Wind Speed** ___ MPH

**Rectal temperature** ___ . ___ ºC / ºF

**WBGT** ___ . ___

**Body Part or Organ System Affected:**

**Ephedra Use:** ○ YES ○ NO

**Previous Heat or Cold injury:** ○ YES ○ NO

**Multi-system involvement:** ○ YES ○ NO

### MALARIA CASES ONLY

**Pertinent Travel:** ○ YES ○ NO

**Country #1** _____

**Country #2** _____

**Malaria Chemoprophylaxis:** ○ YES ○ NO

**Prophylaxis #1** _____

**Prophylaxis #2** _____

# 18th MEDCOM IHO REPORTABLE EVENTS WORKSHEET

## DISEASE DATA

**Diagnosis** (See Reverse for Malaria & Heat/Cold Injuries)

**Onset of Symptoms**

Day ☐☐ Month ☐☐ Year ☐☐☐☐

**Confirmed:**
- ○ YES
- ○ NO
- ○ PENDING

**Method of Confirmation:**
- ○ CLINICAL
- ○ CULTURE
- ○ SLIDE
- ○ BIOPSY
- ○ SEROLOGY
- ○ OTHER

**Admitted:**
- ○ YES
- ○ NO

**Date of Admission**

Day ☐☐ Month ☐☐ Year ☐☐☐☐

### REPORTABLE CONDITIONS LISTS

## TRI-SERVICE

Amebiasis
Anthrax
Biological warfare agent exposure
Botulism
Brucellosis
Campylobacter
Carbon monoxide poisoning
Chemical agent exposure
Chlamydia
Cholera*
Coccidiomycosis
Cold injury, frostbite
Cold injury, hypothermia
Cold injury, immersion type
Cold weather injury, unspecified
Cryptosporidiosis*
Cyclospora
Dengue fever*
Diphtheria*
E. coli O154:H7*
Ehrlichiosis
Encephalitis*
Filariasis
Giardiasis
Gonorrhea
Haemophilus influenza, invasive
Hantavirus infection
Heat exhaustion
Heat stroke
Hemorrhagic fever
Hepatitis A, Acute
Hepatitis B, Acute*
Hepatitis C, Acute
Influenza
Lead poisoning
Legionellosis
Leishmaniasis, cutaneous*
Leishmaniasis, mucocutaneous*
Leishmaniasis, unspecified*
Leishmaniasis, visceral*
Leprosy
Leptospirosis
Listeria
Lyme disease
Malaria, falciparum
Malaria, malariae
Malaria, ovale
Malaria, unspecified
Malaria, vivax
Measles*
Meningococcal dis., Meningitis
Meningicoccal dis., Septicemia
Mumps*
Pertussis*
Plague*
Pneumococcal pneumonia
Poliomyelitis*
Q fever
Rabies, human
Relapsing fever
Rheumatic fever, Acute
Rift Valley fever
Rocky Mountain Spotted fever
Rubella*
Salmonellosis
Schistosomiasis*
Shigellosis*
Smallpox
Streptococcus, Grp. A, invasive
Syphilis, congenital
Syphilis, latent
Syphilis, late (tertiary)
Syphilis, primary/secondary
Syphilis, unspecified
Tetanus*
Toxic shock syndrome
Trichinosis
Trypanosomiasis
Tuberculosis, pulmonary
Tularemia
Typhoid fever
Typhus fever
Urethritis, non-gonococcal
Vaccine, adverse event
Varicella, active duty only
Yellow Fever

## KOREA-SPECIFIC

Asbestosis
Chancroid
Contagious disease in day care
Granuloma inguinale
HIV/AIDS
Lymphogranuloma venereum
Melioidosis
Pelvic inflammatory disease
Rash outbreak
Rhabdomyolysis
Trichomoniasis
URI outbreak

## KOREA Ministry of Health and Welfare Required

African sleeping sickness*
Angiostrongyliasis
Babesiosis*
Chagas diasese
Dengue fever
Ebola fever*
Echinococcosis
Gnathostomiasis
Lassa fever*
Marburg fever*
Newly emerging syndromes*
- Acute neurological disorders
- Acute respiratory symptom
- Acute diarrhea
- Acute hemorrhagic fever
- Acute jaundice

Paratyphoid fever*
Pinta*
Scarlet fever
Vancomycin Resistant Staphlococcus Aureus
Vibrio vulnificus infection
Yaws*

### CATEGORY CODES

| | | | | | |
|---|---|---|---|---|---|
| A11 | Army active duty | F41 | DEP Air Force active duty | N11 | Navy active duty |
| A31 | Army retired | F43 | DEP Air Force retired | N31 | Navy retired |
| A41 | DEP Army active duty | M11 | Marine active duty | N41 | DEP Navy active duty |
| A43 | DEP Army retired | M31 | Marine retired | N43 | DEP Navy retired |
| F11 | Air Force active duty | M41 | DEP Marine active duty | K59 | Civilian/DEP Civilian |
| F31 | Air Force retired | M43 | DEP Marine retired | K79 | Local National |

### PRIVACY ACT INFORMATION

***Authority:*** Section 133, Title 10, United States Code (10 USC 133)
***Purpose:*** The purpose of this form is to compile relevant patient information concerning communicable diseases and injuries occurring among Department of Defense personnel and family members stationed or operating in Korea.
***Routine Uses:*** Used to monitor for the emergence of specific communicable diseases or outbreaks which pose a public health threat and to prepare data for inclusion in the U.S. Army Medical Surveillance System.
***Disclosure:*** The requested information is mandatory for compliance with U.S., Host Nation and Army disease reporting laws and regulations. Failure to provide the requested information will prevent effective public health action and contribute to higher disease and injury rates.